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Hamilton-Wentworth District Health Council. Assessment & Placement Service

Assessment & Placement Service

canadian hospital

An assessment and placement program

Designed to serve the medical and social needs of extended care patients today — while identifying the future need for beds and services

BY J. R. D. BAYNE, M.D.

It is well known that one of the major challenges to health professionals today is the treatment, management and if possible prevention of chronic illnesses and the treatment and care of persons handicapped by them. Acute severe illness or acute episodes of chronic illness may be appropriately treated in general hospitals, but recovery may be slow and in some cases the kind of program needed at this stage may not be well provided in the general hospital. In such a situation high cost services are being wasted and treatment goals are not being met. It may be difficult to find the appropriate facility for care especially if a precise assessment of the mental and physical needs of the patient, his functional capacity, his social and cultural needs and his abilities, motivation, and economic assets have not been evaluated. Placement in an institution for long term care of a person capable of returning home if adequately managed, can be very expensive and in the long run demoralizing.

With improved life expectancy there is prolonged survival of young and middle aged people with chronic disabling disease. Among the increasing numbers of people who reach old age there is a high prevalence of chronic illness. Although people with these conditions overtax the health services as now organized, they do not receive all services appropriate to their needs and have seldom any opportunity to use their remaining abilities to achieve life satisfaction. Lack of coordination and cooperation in planning and service results in inefficient use of extended care facilities that now exist and makes identification of future needs of beds and services impossible. Accurate assessment of the handicapped individual and of the services available must be made. Planning and cooperative health servicing should be organized on a district and regional basis. The Hamilton District Health Council has started such planning and cooperation, and has sponsored an Assessment and Placement Service for Extended care for its district.

The Hamilton District Health Council came into being through the determination of the general hospitals to meet regularly together for mutual planning and coordination of services. Duplication of facilities is avoided and instead certain programs such as treatment of patients with stroke, amputees, and patient requiring renal dialysis, cardiac surgery, and other highly technical and expensive services are located at one of the five hospitals and shared by the others. This Council set up a sub-committee to study the extended care resources of the district in relation to the needs of handicapped people. In its report the sub-committee pointed out the lack of suitable extended care facilities and the inappropriate use of them. It recommended setting up a central Assessment and Placement Office staffed by a Medical Director and Administrator, a Public Health Nurse, a Social Worker and secretarial staff, with responsibility to promote adequate assessment of persons needing long term care or support, their placement in appropriate locations, follow-up and re-assessment where needed. Evaluation of long term care facilities and identification of lacks in community resources were also primary goals. This Assessment and Placement Service (APS) has now come into existence with funding by the Ontario Hospital Services Commission. It is responsible to the Hamilton District Health Council through its Committee on Extended Care.

The service (A.P.S.) is concerned with persons needing long term treatment or placement whether they are at home, in hospital or elsewhere, and helps the family physician in identifying specific needs and what facility can best meet these needs. It helps in placement of persons and will follow-up so that further changes can be made when needed. The program serves the entire community and so will be able to gauge precisely what new treatment or care programmes are needed and for how many people. Its aim is to ensure that no person is neglected or forgotten, and that no family or institution is taxed beyond its limits.

OBJECTIVES OF A.P.S.

The objectives of the service are:

1. To aid health professionals at all levels (a) to identify accurately the total needs of each person requiring long term treatment or care, (b) to locate the facility or program where this can be obtained, (c) to coordinate their efforts to ensure that no person is left out of an appropriate programme, and (d) to use facilities that provide extended treatment or care in the most efficient and effective way.

2. To identify what extended care treatment or support services are needed in what quantities and in what localities

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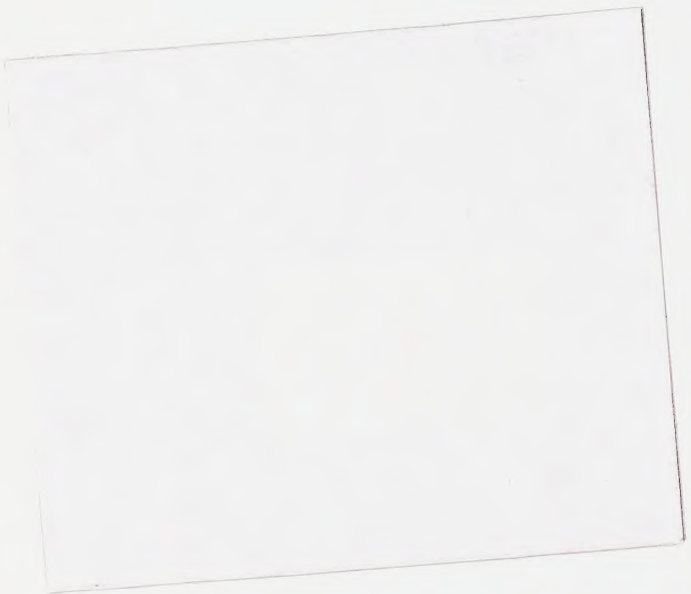

for the district covered by the Hamilton Health Council after all present services are functioning effectively and cooperatively.

3. **To serve as a teaching and research resource in the extended care field and to promote new approaches to the treatment of persons with illnesses and to stimulate interest in this field.**

"The service should serve as a resource for teaching and research"

The Medical Director has obtained an appointment to the staff of all the district general hospitals. He encourages the development of assessment teams in each hospital and an interest in the provision of short term rehabilitative programs. Persons needing such extended care will be identified early by such teams and discharge planning initiated. The Central Office team is informed of the status of each patient and suggests appropriate available placements. The team promotes uniform standards of assessment from one hospital to another and helps establish levels of care requirements for each case. Such levels of care are related to the type of personnel and program that can answer the need and the facility which provides them. The team aids in movement of the patient into the required program (in the same hospital, a rehabilitation facility, a chronic disease hospital, a nursing home, Home for the Aged, Home Care Program, etc.) The team follows up the patient at a later date to see if the program is still appropriate and if the patient is responding. If another placement or a new program is needed, the team will promote its occurrence. It is also possible to see if the previous treatments and decisions were justified by the outcome. The initial and follow-up assessments also enable an accurate picture to be built up of the district needs for programs or facilities for specific purposes and in what numbers and locations they are needed.

This type of program promotes cooperative coordination between institutions so that no patient is left out and movement of a patient from one to another is facilitated. Mutual understanding will ease relationships and mutual support will promote the most effective and efficient use of beds and programs. Such cooperation enables a small number of institutional beds to serve as large number of people but with greater satisfaction to all.

Records in our service are kept in the central office and include information on the person's medical condition, the functional capacity for self care and for occupation, the psychological state and motivation, the social background, family relationships, and cultural links and the economic status. There is an estimate of levels of care and special service needs; the placement or management plan of each person along with the outcome. Records will be useful for follow-up review, or on re-entry into an active phase they will help in planning and placement. Records are kept of the services available in different localities and institutions both for placement of patients and for identification of areas needing improvement. From the records it will be possible to review each decision, analyse its effectiveness and improve in future judgments.

Information is recorded in easily accessible form and suitable for computer analysis. These forms were developed by the central office staff with advice from the Department of Clinical Epidemiology and Biostatistics, McMaster University, the Provincial Department of Health, Ontario Hospital Services Commission and many others.

Evaluation of the effectiveness of this program will be one of the functions of the central office staff on an on-going basis. The questions that will be repeatedly reviewed are whether the service is easily available to all physicians and patients and well understood, and if it facilitates communication between health professionals in planning for extended care of patients.

To be effective the service should facilitate placement of persons needing extended care, by enabling more people to be placed in community programs or extended care institutions and by reducing the interval between acceptance for admission and actual admission to the facility. The placement should be appropriate to the person's needs as seen at the time, but the central office records will show if a compromise had to be made because of lack of adequate accommodation. The problems occurring after placement, and whether or not these problems were due to inadequate assessment will also be indicated on the record. The service then should be able to identify lacks in the present range of extended care services and re-duplication and report these to the Hamilton District Health Council, and what is required in planning, coordination, facilities, staff, financing or legislation. Finally the service should serve as a resource for teaching and research to provide better informed health professionals and more effective treatment methods.

Identification by the Assessment & Placement Service of the Numbers and Care Needs of Ambulant Confused Persons

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The Assessment & Placement Service (APS) of the Hamilton Wentworth Health Council has developed an assessment form that assists the physician and associated health professionals to identify the diagnosis and prognosis, the mental and physical functional status, the social background, and the care needs of persons with chronic disabling disease requiring long-term management. Between September 1971 and December 1976 12,252 referrals were received. On the basis of the information provided, an APS counsellor guides these professionals in finding and using resources appropriately. Analysis of this information is reported for the 205 referrals received in 1975 and 1976 in which the person was stated to be severely impaired in judgment and comprehension but was ambulant. The analysis shows that the majority were elderly, female, never or no longer married, and that about one-third had no one available to provide help. Although almost half were continent and could feed themselves, almost none could bathe, keep house, or manage medications or their personal affairs. The locations to which they were sent varied in accordance with the particular needs in each case for care and management.

Many surveys have shown that a significant number (5%) of those aged 65 or over have impaired mental function, and the percentage increases for those 75 or over. Such impairment does not necessarily require treatment in a mental hospital. However, due to frequent association with physical disease elsewhere in the body, these people often have personal care and treatment needs for medical and nursing services (1, 2). Those with severe physical disability usually require admission to a hospital or nursing home.

A difficult group to find services for are those who can get about but have significant impairment of memory and judgment and who, because of their mobility, present special problems of protection and care. It is hard to manage such a person in a private residence or an institution where access to the street or other potentially dangerous environments cannot be controlled. They are often therefore physically restrained, or restrained by tranquillizing medication, both for their own protection and to prevent them from disturbing other people. Yet such restraints may compound the difficulties by inciting them to violence or loud protestation, or by so sedating them that they become dehydrated, malnourished, or immobile. There has been a strong temptation to seek admission to a psychiatric hospital where protection can be provided without severe limitation of mobility. This action is not favoured by psychiatrists or psychiatric hospital staff because apart from protection, these patients have no need of the many other services they offer. What is required are: a sympathetic reassuring approach; an environment that allows freedom of movement with protection from wandering, and falling, from the hazards from dangerous equipment or the unscrupulous; and the provision of such personal care as they require.

The Assessment & Placement Service (APS) of the Hamilton Wentworth District Health Council was established in 1971 with funding by the Ontario Ministry of Health (3). Its aims and purposes are: (a) to promote better assessment of the needs of persons with long-term disabilities utilizing the personal physician and other health personnel closely associated with the patient; (b) to find appropriate programs that can meet these needs and to identify whatever modifications or new approaches might be required; (c) to provide a resource for the education of health personnel in the complex needs of the chronically ill and handicapped (4). Information is obtained using a precoded assessment form which is completed by the treating physician and a public health nurse if the person is at home, or the treating physician and a nurse and social worker if he is in hospital. A recommendation on appropriate and available resources is returned to these professionals for final decision and action. By December 1976 APS had received 12,252 referrals.

In order to obtain information on

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TABLE I.
Frequency of Diagnoses in APS Referrals for 1975 & 1976

Diagnoses (not mutually exclusive)	Frequency	Percentage of all Diagnoses
Senile & Presenile Dementia	66	11.8
Generalized Ischaemic Cerebrovascular Disease	60	10.7
Psychosis associated with other Cerebral Condition	42	7.5
Chronic Ischaemic Heart Disease	34	6.1
Arteriosclerosis	23	4.1
Diabetes Mellitus	18	3.2
Cerebral Thrombosis	16	2.9
Essential Benign Hypertension	16	2.9
Symptomatic Heart Disease	15	2.7
Osteoarthritis and Allied Conditions	9	1.6

Number of diagnoses recorded: 561
Average number of diagnoses per referral: 2.7

those persons with impaired mental function who are ambulant, APS has analyzed the data recorded for the 4,204 completed referrals received in 1975 and 1976.

Data were retrieved by computer on all cases for 1975 and 1976 where the person was fully ambulant or independent with a cane or wheelchair ("ambulant"). There were 1,707 such referrals. From them the referrals were retrieved in which the physician indicated judgment was grossly impaired or there was inability to make any judgments, and in which the nurse indicated that the person was barely able or unable to comprehend the present life situation. There were 205 with this degree of impaired mental function.

The ten commonest medical diagnoses listed in these referrals are shown in Table I. It can be seen that organic disease of the brain featured prominently. Table II shows the age and sex distribution and that most were over age 64 (164), although 5 were under 45. Over the age of 75, women predominated. The referrals indicated that 11% were single, 37% married, 43% widowed, and 6% divorced or separated. (Data were missing for 3%). The person managing the client's affairs was the spouse in 28%, children in 25%, a lawyer or public trustee in 8%, the client in 8%, and other persons in 16%. (Data were missing for 15%). The previous living accommodation was a house for 50%, an apartment for 27%, a room for 8%, other accommodation for 4%, and an institution for 6%. (Data were missing for 5%). As might be expected from the considerable percentages of single and widowed, there was no one available to provide assistance to 34%. Someone was able to give partial assistance to 36%, and full assistance was available for 17%. (Data were missing for 13%).

The amount of personal care needed can be seen from Table III. Although a considerable number were continent and could feed themselves, very few could carry out complex tasks such as dressing, housework, cooking, or managing affairs or medications.

In addition to indicating the impairment of judgment, the physicians also recorded that in 45% of referrals the person was moderately or severely depressed, and in 30% moderately, severely, or extremely anxious. 31% were markedly or extremely withdrawn, and 15% were rarely or never cooperative. Services required according to the referring physicians included sterile dressings in 8 referrals, a urinary catheter in 25, and a special diet in 32.

The recommendations made by the APS counsellor were based on the care needs of the person as shown on the referral form and any particular cultural, language, or career background factors that would make a particular

TABLE II.
Age and Sex Characteristics of Ambulant Persons with Impaired Judgment and Comprehension

Age	25-34	35-44	45-54	55-64	65-74	75-84	85 +	Total
Male	1	3	4	16	27	29	12	92
Female	0	1	6	8	18	55	23	111
Total	1	4	10	24	45	84	35	203

Missing Data = 2, N = 205

TABLE III.
Personal Care Needs of the Mentally Impaired Ambulant

	Able %	Impaired %	Unable %
Continence of Urinary Bladder	45.8	33.8	20.4
Continence of Bowel	49.0	40.0	11.0
Feeding	51.0	43.0	6.0
Dressing	17.0	59.0	24.0
Bathing or Washing	4.4	62.8	32.8
Keeping House	0	12.0	88.0
Preparing Food	1.0	6.0	93.0
Using the Telephone	4.0	20.0	76.0
Managing Affairs	0	1.0	99.0
Managing Medications	0	2.0	98.0

recommendation more appropriate. Analysis of the data (5) has shown that the counsellors' recommendations did reflect the care needs and that actual placement did correspond to the recommendation.

For the purpose of this study a telephone follow-up was carried out in July 1977 to find out where those referred then were. The placement location when the referral was completed in 1975 or in 1976 can be seen from Table IV, with the location on follow-up in July 1977, i.e., at least 6 months later for those referred in 1976, and at least 18 months later for those referred in 1975. 47 referrals were withdrawn; this was due to a decision to remain at home, or a change in health that necessitated re-referral. At the time of the follow-up a considerable number were still capable of being managed in a private residence or a Home for the Aged. However, death was not uncommon. In addition to 21 deaths during the referral process, 43 deaths occurred after the referral process was completed, making a total of 64 deaths among 196 persons referred.

Discussion

The population served by APS is approximately 407,000 of whom 9.7% are 65 or over (6). In 1975 and 1976, 4,202 referrals were received requesting assistance in identifying long-term care resources. Over 80% of these referrals were for those 65 or over, and in only 20% of the referrals was mental function considered fully normal. 205 referrals for 196 persons indicated severely impaired judgment and comprehension, as assessed by two professionals, but with preservation of ability to walk or get about in a wheelchair. Present knowledge does not allow hope for cure, but because of their limited understanding, these people must be managed with both compassion and skill. They need to be located in an environment that provides protection from wandering and injury, but that allows for some freedom of movement without disturbance to others. They need to be helped by people who will encourage their participation in a simple, familiar, repetitive, personal routine, and who can provide reassurance and guidance. Verbal communication can be difficult, so comforting gestures and warm bodily contact should be frequent. Tranquillizing medication may relieve anxiety but must be carefully controlled and used only when specifically required. Incontinence may be lessened by a regular toilet routine but not eliminated, and both clothing and furniture must be chosen carefully. Other illnesses may well occur and can be identified by regular visits by an interested physician. Treatment requires careful judgment on his part, and discussion with the family on how intensive treatment should be when such intercurrent or new disease appears.

The physician must be certain of the diagnosis and that a curable disease is not present. He should then help the family to accept the slow decline in function and in deciding what their involvement will be. The need for institutional care can be reduced by a community support program that advises and assists families and friends in retaining the mentally-impaired person in familiar surroundings for as long as possible.

Management at home may be possible for a time, but when extensive personal care is required, it may be both in the patient's and the family's best interests to arrange for institutional care. A facility is then required that can provide the personal nursing care and supervision, the control of movement, and the necessary interest and understanding. However, even with skilled and sympathetic care survival may be curtailed in this group of severely impaired people. APS has developed an assessment form that promotes identification of the functional status of the person and the social background, and is able, based on the information obtained, to guide the treating health professionals in finding appropriate resources and in gaining entry to them when the time comes.

TABLE IV.

Location on Completion of the Referral and on Follow-up

	Location on Completion (Referrals)	Location on Follow-up (July 1977) (Persons)
Private Residence	16	37
Home for the Aged	9	13
Nursing Home	81	48
Chronic Hospital	24	15
Psychogeriatric Unit	3	11
Other	4	2
Referral Withdrawn	47	
Deceased	21	64
Moved from Area		6
Total	205	196*

*9 persons re-referred

Acknowledgements

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Le Service d'Évaluation et de Placement (SEP) du Conseil de Santé de Hamilton-Wentworth a élaboré un formulaire d'évaluation pour permettre aux médecins et aux professionnels affiliés de la santé à identifier le diagnostic et le pronostic, l'état fonctionnel mental et physique, le milieu social et les besoins de soins des personnes atteintes de maladies chroniques débilitantes exigeant des traitements à long terme. Entre septembre 1971 et décembre 1976, 12,252 cas ont été répertoriés. En fonction des informations reçues, un conseiller SEP oriente ces professionnels à partir de ces données pour leur permettre d'utiliser les ressources de façon efficace. On rapporte l'analyse de cette information pour 205 cas enregistrés en 1975 et 1976 où l'on constatait que la personne avait un jugement et une compréhension considérablement affaiblis mais était sur pied. L'analyse montre que la majorité des cas étaient des femmes âgées, jamais ou plus mariées et qu'environ un tiers d'entre elles n'avaient personne pour les aider. Bien que près de la moitié étaient continents et pouvaient se nourrir, presque personne ne pouvait se baigner, vaquer aux affaires de la maison ou veiller à prendre ses médicaments ou encore gérer ses affaires personnelles. Les établissements où ces personnes étaient envoyées variaient selon les besoins de chaque cas au plan des soins et des traitements.

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Identifying Needs and Services for the Aged*

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ABSTRACT: The Assessment and Placement Service (APS) of the Hamilton-Wentworth District Health Council assists health professionals in identifying the needs of persons with chronic disabling diseases, and in finding appropriate resources or programs. More than 80 percent of the 9,300 persons referred between September 1971 and December 1975 were over the age of 64. Although most referrals were local, some came from as far away as British Columbia and Florida for persons wishing placement locally. Of the 2,005 persons referred and placed in 1975, 1,063 came from acute disease hospitals, 201 from other institutions, 628 from the community within this District, and the remainder from elsewhere. There were 1,187 women, of whom 89.5 per cent were over the age of 64, and 811 men, of whom 65.8 per cent were over that age. In the opinion of their physicians, only 20 percent of all persons referred had normal memory, and only 13 percent had normal judgment. In the 64+ age group, 71.1 percent of the women were widows, and 25.9 percent of the men were widowers. One-third of those referred were living alone, and one-fourth with a spouse only. For placement, 453 patients went to private residences or boarding homes, often with the support of community services, and the remainder went to various institutions according to identified needs. Follow-up contact one month later showed conditions to be satisfactory in most instances. Deficiencies in the health care system were identified and reported to the Health Council.

Canada has only recently joined that group of countries in which 8 percent of the total population is aged 65 or more, a group designated by the United Nations as "old" (1). However, in the next 25 years the numbers of people in this age group will double and those over 75 will increase even faster. If the birth rate and immigration continue as forecasted, the aged will then constitute 11 percent of our population. Despite the advanced medical service organization in Canada, most communities report the inappropriate use of acute-disease services by the aged and long-waiting lists for maintenance and support services. With a smaller percentage of the population over age 65 at present than in Britain and Western Europe, Canada already has a higher percentage under institutional care (2). The World Health Organization Expert Committee on Planning and Organization Of Geriatric Services (3) has pointed out that the elderly are likely to manifest chronic disabling disease and may have psychologic disorders as well. These require careful assessment and appropriate treatment. However, as services are developed, they must be coordinated to ensure accessibility and efficiency and to promote a balance between demand and supply.

THE ASSESSMENT AND PLACEMENT SERVICE

Purpose and methods

The Assessment and Placement Service (APS) (4) of the Hamilton-Wentworth District Health Council was set up in 1971 with funding from the Ontario Ministry of Health with three objectives: (a) promoting better assessment of the needs of persons with long-term disabilities, utilizing the personal physician and other health personnel closely associated with the patient; (b) finding

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appropriate programs that could meet these needs and identifying any modifications or new approaches that might be required; and (c) providing a resource for the education of health personnel in the complex needs of the chronically ill and handicapped (5).

The general service area includes the city of Hamilton, Wentworth County and the city of Burlington, although referrals are accepted from outside this area (a population of approximately 500,000).

The service receives referrals for people of any age and with any mental or physical disability but over 80 percent of the 9,300 referrals received between September 1971 and December 31, 1975, were for people over the age of 64. This reflects the high prevalence of disabling disease in this age group and the difficulties many have in continuing independent living.

Information is obtained through a precoded assessment form which is completed by the treating physician and a public health nurse if the person is at home, or by the treating physician and a nurse and social worker if the person is in the hospital. A recommendation as to what resources seem appropriate and are available is returned to these professionals for final decision and action.

Statistical data

During the year 1975, the APS received 2,472 referrals, of whom 2,005 were placed and 467 were still awaiting placement in January 1, 1976. The average number of persons awaiting placement at any time during the year was 420, varying from 357 in March to 570 in July.

Table 1 shows the numbers waiting for admission to various types of care and services, meanwhile living at home and or in an acute disease hospital, for a sample month (November 1975). As one would expect, relatively few people could wait at home for admission to a chronic disease hospital and few people were waiting in acute disease hospitals for return to community living.

Referrals came from as far away as British Columbia, Montreal and Florida (e.g., for people taken ill on vacation and requiring long-term care on their return). Placements have been made to other areas in Ontario, and four patients were placed outside Ontario. The majority of referrals and placements were within the cities of Hamilton and Burlington and Wentworth County. The population of Hamilton and Wentworth County by 1971 census was 401,883, of which 35,490 were aged 65 or over (8.8 percent). The city of Burlington, by the 1971 census, had a population of 87,025, of which 4,350 were aged 65 or over (5 percent).

Table 2 shows the location of the patients at the time of referral. Of the 2,005 whose placements were completed, 1,062 came from acute disease hospitals in the area and 201 from other facilities such as chronic disease hospitals, nursing homes, and homes for the aged. Six hundred and twenty-eight referrals came directly from the community, initiated by the family physician, other health professional, a family member, friends, or the person himself. Seventy-one referrals came from hospitals or facilities outside the area, and 38 from outside communities.

As in previous years (6), referrals of women (1,187) outnumbered those of men (811). [In 7 additional acases the data were incomplete.] Table 3 shows that 89.6 percent of females referred were in the age group over 64 whereas 65.8 percent of males were in this group. It is evident that men were referred at an earlier age than women, there being 13.8 percent in the 55–64 decade compared to 6 percent of the women, and the number of males in each decade under 65 being greater than the number of females. This is due to the greater severity of chronic illness in men com-

TABLE 1

Location of Persons Awaiting Placement, November 1975 (N = 397)

Awaiting Placement in	Current Location: Acute Disease Hospital	Current Location: Home
Rehabilitation units	15	3
Chronic disease hospitals	67	25
Nursing homes	65	66
Homes for the aged	16	58
Support services in community	14	68
Totals	177	220

TABLE 2

Location at Time of Referral

Location	No. of Persons	Totals
McMaster University Medical Centre	85	
Chedoke Hospital	74	
Henderson Hospital	323	
Hamilton General Hospital	177	
St. Joseph's Hospital	288	
Joseph Brant Memorial Hospital	115	1,062
Hamilton-Wentworth Burlington Community	628	628
Long-term care facilities	201	201
Outside communities	38	
Outside long-term care facilities	71	109
Data missing		5
		2,005

pared to women of the same age and is reflected in men's lower life expectancy.

Table 4 shows that among those referred, the percentage of widows over age 64 (71.1 percent) was considerably greater than that of widowers (25.9 percent), and the percentage of married women over 64 (16.25 percent) was less than that of married men (33.9 percent). The higher percentage of men married than widowed is due to the fact that men usually are married to women younger than themselves, and to the greater survival ability of women.

Table 5 shows the ten most frequent diagnoses, according to the International Classification of Diseases. Three hundred and twenty-six different diagnoses were made by the referring physicians, with a total of 4,921 for 1,982 referrals in which they were listed (an average of 2.8 diagnoses per referral). Among the commonest diagnoses, four involve and affect cerebral function. It would seem that impaired mental function is a frequent antecedent to referral for help in long-term management.

Table 6 shows the appraisal of memory and judgment made by the referring physician. Clearly, only a minority of the patients were considered to have normal memory or normal judgment. Taking items 4 and 5 together in each category as indicating severe impairment, 497 patients had severe memory impairment and 494 had severe judgment impairment. In 258 referrals the physician did not record this function.

The recommendation made by the APS counsellor is based on the clinical picture obtained from the referral form augmented by information obtained through telephone contact with the referring health professionals, coupled with personal knowledge of the many services and facilities and the corresponding administrative and treating staffs. The counsellors are nurses who have the professional background to understand the clinical implications of the information on the form, and have also the tact and diplomacy to obtain further information, to suggest further investigation and finally to negotiate as a broker for acceptance of the applicant into the recommended program.

The placement arrangements are not made by the counsellor but by the health professionals dealing with the applicant when they know what is available, and the decision to act on the recommendation or not can be worked out by them and the applicant and family together.

TABLE 3

Ages of Men and Women, by Decades

Decade	Men	%	Women	%
85 or over	126		311	
75–84	252	65.8	455	89.6
65–74	186		218	
55–64	103	13.8	66	6.0
45–54	49		38	
35–44	14		9	
25–34	7		6	
under 25	7		4	
Totals	744		1,107	
[Data missing]	[67]		[80]	

TABLE 4

Marital Status of Men and Women over Age 64

Marital Status	Men	%	Women	%
Single	104		114	
Married	338	33.9	246	16.25
Divorced	34		16	
Separated	59		24	
Widowed	209	25.9	707	71
Totals	744		1,107	
[Data missing]	[67]		[80]	

TABLE 5

Ten Most Frequently Listed Diagnoses

Diagnosis	Absolute Frequency	% of 4,921
1. Generalized ischemic cerebrovascular disease	329	6.7
2. Chronic ischemic heart disease	220	4.5
3. Senile or presenile dementia	219	4.5
4. Cerebral thrombosis	212	4.3
5. Symptomatic heart disease	199	4.0
6. Diabetes mellitus	184	3.7
7. Other types of cerebral paralysis	181	3.7
8. Essential benign hypertension	160	3.3
9. Fracture of neck of femur	137	2.8
10. Arteriosclerosis	135	2.7
Total	1,976	40.2

Number of diagnoses recorded	4,921
Number of different diagnoses recorded	326
Average number of diagnoses per referral	2.8

TABLE 6

Status of Memory and Judgment, as Recorded by Attending Physician on page 1, Assessment Form, Section B, 1975

Status of Memory	No. of Patients	
1. Normal	414	
2. Brief periods of forgetfulness	432	
3. Brief periods of confusion	404	
4. Periods of marked confusion	377	497
5. No recall	120	
Data missing	258	
Total	2,005	

Status of Judgment	No. of Patients	
1. Normal	259	
2. Adequate for personal safety	412	
3. Limited	582	
4. Gross impairment; unrealistic	255	494
5. Unable to make any judgment	239	
Data missing	258	
Total	2,005	

It should be noted that some applicants require more than one placement recommendation, e.g., rehabilitation followed by admission to a Home for the Aged. Therefore, in 1975, of 1,519 placements made, 1,286 were first ones, 208 second, and 25 third placements.

Table 7 shows the location of the placements made. Eight hundred and thirty-nine placements were made to long-term treatment or care facilities within the health district, and 65 to such facilities outside the district. Four hundred and fourteen placements were made to a private home, lodging house, or boarding house within the health district and 39 to such accommodation outside the district. One hundred and forty-nine persons were admitted to an acute disease hospital within the district and to 9 such hospitals outside the district.

Most of those admitted to acute disease hospitals were not placed there on the recommendation of APS, but because of a deterioration in health occurring after referral. In these situations the hospital was usually notified of the previous referral to APS and the suggestion was made that a new referral could be submitted when further placement was required to ensure early referral.

Four patients were placed outside Ontario, 216 refused any placement, 301 died before placement was carried out and 179 experienced a major change in condition that required re-referral for a new evaluation. It appears that many people who refuse placement do so because they are reluctant to surrender their independence. These people often approach APS again within months, by which time there may be a change in condition necessitating a re-referral. The altered condition may be due to gradual deterioration or a sudden change such as a stroke or a fracture.

TABLE 7

Location of Placements

Location	H-W.B*	Outside H-W.B	Outside Ontario
Chronic disease hospitals	252	7	
Nursing homes	394	29	
Homes for the aged	57	15	
Rehabilitation units	126	–	
Hamilton Psychiatric Hospital	10	–	
Homes for special care	–	4	
Other facilities	–	10	
Totals	839	65	
Private residence	216	31	
Lodging house	81	5	
Day care centre	33	–	
Home care program	78	3	
Other	6	–	
Totals	414	39	
Acute disease hospitals	149	9	4
Grand totals	1402	113	4

* Hamilton-Wentworth Region and Burlington.

Any dissatisfaction with the placement is usually immediately expressed to APS by the family or institution and action is taken to provide further help or to place the person elsewhere. This has rarely happened. As a further check, a letter is sent one month after placement to the applicant; or if he is confused, to the family; or if there is no family, to the program. Replies are received in approximately 80 percent of cases, and persons not replying are reached by telephone. It is rare that significant dissatisfaction is expressed, but any criticisms that may be received are noted.

COMMENT

A number of deficiencies in the health care system have become clearer:

1. Some referrals from acute disease hospitals indicate that the person had been slowly declining at home and had had very little assistance or encouragement from any health services until an acute social crisis occurred that precipitated hospital admission. Return home after this is often strongly resisted even if the person improves greatly over his previous condition. A mechanism for identifying these cases is being worked out with the Bed Utilization Committees of the acute disease hospitals, through the Health Council.

2. Many people requiring extensive nursing care wait in acute and chronic disease hospitals for accommodation in nursing care facilities. The available places in such facilities appear to be taken by people needing much less care, who could be managed at home if sufficient community services existed. The problem does not seem to be a deficiency of beds but rather an inappropriate use of them. APS is reviewing the referrals of those persons for whom the recommendation was noninstitutional care, but who were admitted to nursing homes. They will be studied to see if such care was required.

3. Community support programs such as Home Care can be effective in helping the patient stay at home but the requirement for service and the effectiveness should be evaluated for cost control. This problem area is being examined by a task force of the Health Council.

Thus the APS has a dual role as: 1) a clinical service organization providing advice and guidance in professional management, and 2) a fact-

finding organization that contributes to evaluation of present services and to future planning.

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